601. C-7.2 Objective 2 - Objective 2 states "Beneficiary extreme satisfaction with each and every service provided by the contractor during each and every contact." How does the Government intend to define and determine 'extreme satisfaction' as stated in this objective, and how will the contractor's performance be measured against this Objective?

RESPONSE: *Revised 25 October 2002.*

RESPONSE: The government first notes that the language quoted was revised via Amendment one to read: ". . . Beneficiary must be highly satisfied with each and every service provided by the contractor during each and every contact." As the five evaluation subfactors of the technical approach correspond with the five Government objectives, the offeror's proposed methods and performance standards should be designed towards achieving the Government's objectives. Performance standards proposed by the successful offeror will be incorporated into the contract. The Government will measure the contractor's performance against both the Government minimum standards, set forth in the RFP and incorporated documents, and the contractor's proposed standards. The contractor's success in achieving these standards will serve as the Government's measurement tool for assessing the contractor's success in achieving the objectives. Award Fee will be determined in accordance with procedures set forth in Attachment L-3.

602. C-7.28 - Requires the contractor to locate a senior executive within a 15-minute drive of the Regional Administrative Contracting Officer's office. Where will the Regional Administrative Contracting Officer be located? Will they be co-located with the Regional Director? Will there be only one per region? This information is needed to develop a cost proposal.

RESPONSE: There will be Regional Administrative Contracting Officer(s) in each region and co-located with the Regional Director. See Question 21(f) for regions.

603. C-7.41 - Cost trends will influence the "national trend" used by the government. To what extent and when will the contractor have access to pharmacy data that reflects utilization of pharmaceuticals by beneficiary?

RESPONSE REVISED 25 November 2002
RESPONSE: If you are concerned about the national trend in calculating the target cost, the "national trend" is calculated using only data from the three contracts to be awarded from this solicitation and; thus, will not include drug utilization costs from either the Retail Pharmacy contract or the TRICARE Mail Order contract. See the response to Q. 75. Please also see the answer to Question 1230.

The MCSC will not have access to TRICARE Mail Order Pharmacy or TRICARE Retail Pharmacy data as this data is outside the scope of this contract.

604. C-7.42 - Requires the contractor to provide pharmaceuticals to beneficiaries in situations where pharmaceuticals are not obtained from a retail pharmacy and consistent with the coverage usually provided under outpatient pharmacy benefit. Can you be more specific as to what sort of pharmaceuticals you are referring to? Does this include chemotherapy or drugs for the treatment of HIV?

RESPONSE: Examples may include the administration of chemotherapy in a provider's office or clinic, and IV antibiotic therapy delivered by a home infusion service as part of the Home Health Care benefit.

605. C-7.5 - Utilization Management (UM) decision notification: The government requires that UM decisions be reported to the MTF commanding officer on the "day the decision is made." UM decisions may be made on a frequent basis such as that which would occur in the case of a critically ill patient, e.g. there may be UM decisions regarding transition from a higher/lower level of care. To what extent does the government expect/require the contractor to report all of these UM decisions that may be made on an hourly/daily basis?

RESPONSE: The Government expects the contractor to report these decisions in a frequency that will allow the MTF Commander an opportunity to intervene, if appropriate. The frequency can be agreed upon in the MOU between the MTF and the contractor.

606. C-7.7 L Sub factor 3d, and OPM, Ch. 7, Ch. 16, Addendum A - The RFP indicates that the contractor's medical management program "must fully support the services within the MTF." To what extent does the government intend the contractor to be involved/support in the medical management policies and procedures and the day-to-day utilization management activities? Will the government provide a copy of the utilization management plan for each MTF in the regions? Will the government provide detailed information regarding medical management program performance metrics such as admits/1,000 beneficiaries (by class AD, ADD, NADD, Medicare) and length of stay by DRG? Will there be information provided on referrals/MTF provider and referral rate/beneficiary and similar metrics? Should we assume that the contractor will have the opportunity to provide utilization management and case management to persons receiving care in the MTFs?

RESPONSE: The offeror's medical management program must support the MTF through referral management, case management of high cost and identified diagnosis management, etc. The MCSC will not have any involvement in the day-to-day medical management within the MTF, with these exceptions. The Government will not be providing the information and data referenced as the MCSC will not be performing services in the MTFs except in the limited situations specified.

a. It appears that we will determine in MOUs with MTF Commanders whether contractor staff will have any responsibility making appointments and recording info on CHCS. Is this true?

RESPONSE: No, there are no requirements in this contract for making appointments or recording information on CHCS.

b. Please describe the type of coordination that would be required with the HBA if the MCSC were authorized by the MTF Commander to issue Non-availability Statements.

RESPONSE: Coordination at this level is reserved for the MOU.

607. C-21.15. - Enrollment: Is a signature required on the enrollment form?

RESPONSE: Yes

608. E-3 Inspection Locations - "Inspection Locations" states that all inspections shall be conducted either at TMA, the contractor and/or subcontractor's facilities, Lead Agent offices, or other locations where work is performed. Does the reference to the Lead Agent refer to the Regional Director?

RESPONSE: Please see response to question #45.

609. F.5.C(13) - Network Adequacy Reports requires that one copy of the report be submitted to the Lead Agent. However, Section G-2 does not mention the inclusion of the Lead Agent, and the Statement of Work (SOW) refers only to MTF Commanders. Does this requirement refer to the Regional Director rather than the Lead Agent?

RESPONSE: Yes, it refers to the Regional Director.

610. H-1a - This section indicates that "cancer/clinical trials" is an indicated exception. Would the government please clarify whether cancer is an exclusion or is the reference to cancer/clinical trials or only to cancer AND clinical trials?

RESPONSE: Please refer to the TRICARE Policy Manual for a full explanation of the cancer clinical trials program. The exclusion refers to the DoD Cancer Prevention and Treatment Clinical Trials Demonstration.

611. H-1 b.(2)(c) - The actual underwritten health care cost is to be multiplied by the "national trend factor." What is the exact methodology and assumptions that will be used by the government in determining this trend factor?

RESPONSE: See the responses to questions numbered 76 and 317.

612. H-11.b(1)(a) - Sampling methodology A: On page 57 of the RFP, there is a reference to a 90% confidence level for non-denied payment samples with a precision estimate of 1%, whereas on page 53, there is a reference to an 80% confidence level. Will the government consider using an 80% confidence in the sampling methodology in order to determine error rebuttal methodology?

RESPONSE: Please clarify your question as both references refer to a 90% confidence level which is the Government's intent. The denied payment sample design uses an 80% confidence level.

613. L-2 Past Performance - Please confirm that based upon para. L-2 the offeror is to develop a past performance deliverable constructed as a five section document as follows:

a. First section is the narrative information describing our experience (25 page limit)

RESPONSE: This is correct.

b. Second section is the client past performance reports (no page limit)

RESPONSE: This is correct.

c. Third section is the key personnel information (no page limit)

RESPONSE: This is correct.

d. Fourth section contains copies of the final reports and/or findings for only subcontractors (no page limit)

RESPONSE: We will clarify in an amendment that this provision applies to the prime and any subcontractor.

e. Fifth and final section is the "roadmap" of organizational changes (no page limit)

RESPONSE: This is correct.

614. L-2 (b) - Please define the information you are looking for as "supporting documentation".

RESPONSE: This requirement has been removed.

615. L-2 (d) - Is the client signature on past performance reports required 60 days prior to the past performance submission date or 60 days prior to the full proposal submission date?

RESPONSE: Within 60 days prior to the submission of the technical and price proposals.

616. L-2 (d) - Please confirm that Attachment L-4 is the past performance report referenced in para. L-2 (d).

RESPONSE: Confirmed

617. L-2 (h) - Please confirm that the key personnel background submissions are requested for only the top-level personnel.

RESPONSE: The offeror is required to identify the key personnel they will employ in a manner that will allow the Government to assess the offeror's ability to successfully deliver the services the Government is purchasing.

618. L-2 (g) - Please confirm that the Attachment L-4 referenced in para. L-2 (g) should be Attachment L-5.

RESPONSE: You are correct. Amendment 0001 includes this correction.

619. L-3 - The sample survey provided in Attachment L3 indicates that an assessment of a beneficiary's satisfaction for an outpatient visit will be surveyed. To what extent will the government conduct surveys that measure beneficiaries' satisfaction for inpatient and other locations, venues, and types of care?

RESPONSE: For the purposes of the award fee, the beneficiary satisfaction survey is only focused on outpatient services.

620. L-7 - When will we receive information on:

a. Telephone receipts by Claims, HCIL, BSR, HCF, MH.

b. Correspondence Inbound vs. outbound.

c. Call average talk time by Claims, HCIL, BSR, HCF, MH.

RESPONSE: The Government, through the RFP attachments, has provided all available information. Offerors are encouraged to recognize that the information provided is reflective of current requirements which differ from those in this RFP. Offerors must construct their bids based on the requirements contained in this RFP and the offeror's own model for the delivery of these services.

621. L-12.f.(1)(a) - Requires the offeror to submit their proposed performance standards for accomplishing the requirements specified in the RFP. Does that include all requirements listed in Section C or only the specific standards listed in H-8?

RESPONSE: Includes all requirements. The Government is allowing offerors to propose their best practices to include the standards to which the offeror will be held. This applies to each function. For example, an offeror might propose a TSC wait time standard of x minute.

a. In order to calculate a percentage and identify the current primary care and specialty providers, the government would need to provide to the offerors the identity of the network providers currently. Will the government consider providing this information to the offerors?

RESPONSE: Revised 26 September 2002
RESPONSE: The provider directories will be provided by the Government.

b. Health Evaluation Assessment Review (HEAR) is not mentioned in the TOM and TPM. Will the MCS contractor be given the HEAR data for proposal purposes?

RESPONSE: No, the HEAR is not a component of this RFP.

622. TPM, Chapter 8, Section 2.1. TOM, Chapter 8, Section 4, subsection 6.2.3 - Is there a national contractor for DME? If so, how do we interface?

RESPONSE: No, the MCSC is the DME contractor.

623. C-7.7 - Where are NAS requirements stated for a) 40 mile catchments areas (MTF), b) 200 mile catchments areas (regional), c) national catchments areas (STS). A search of TOM and TPM for STS and specialized treatment does not provide guidance. TOM Chapter 20, Section 2 only talks about exemptions from the STS requirements.

RESPONSE: ***revised 20 September 2002***

RESPONSE: Inpatient NAS requirements for the 40-mile catchment areas are stated in TPM, Chapter 1, Sec. 6.1. Since the STS program will be terminated on May 31, 2003, there should be no references to STS NAS for 200-mile or national catchment areas in the TNEX manuals. A future amendment will delete the STS reference in TOM, Chapter 20, Sec 2.

624. C-7.7., 32 CFR, Part 199.4, 6/25/02 version - Page 40 states that maternity cost-shares are subject to applicable NAS requirements. Where are those requirements listed? TPM Chapter 11, Section 2.3 says that birthing centers require an NAS. TOM, Chapter 1, Section 6.1 does not list maternity care as exempt from NAS requirements.

RESPONSE: ***revised 20 September 2002***

RESPONSE: The NAS related language in 32 CFR will be amended to comply with the requirements of the DoD Authorization Act for FY02 which eliminates the maternity NAS effective Dec 28, 03, or the start date of TNEX whichever is earlier. We project publication of the rule in the Federal Register no later than October 28, 03, to amend the 32 CFR. Consistent with the requirements of DoD authorization Act for FY02, TPM Chapter 1, Sec. 6.1, paragraph II.A. requires NAS for inpatient mental health services, and paragraph II.D. indicates no exemption for maternity care from NAS elimination. Paragraph III.A. in Section 2.3 of Chapter 11 was inadvertently left in TPM and it is being deleted in a future amendment.

625. C-7.7. MH/SA: TPM Chapter 7 - Adjunctive Dental: TPM Chapter 9. TOP: TPM Chapter 12. Is it possible for an MCSC to waive the benefit limitations in the TPM or 32 CFR, Part 199?

RESPONSE: No

626. C-7.7 There is discussion of authorization requirements for specialty care in 32 CFR Part 199.17 p. 302-314. TOM Chapter 7, Part 2 only lists authorization requirements for adjunctive dental, mental health, substance abuse, PFPWD, and hospice. TMA's instructions for use of the Policy Manual state "This Manual provides guidance, policy interpretation and decisions implementing TRICARE, including those policies and procedures applicable to the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). The TRICARE Policy Manual contains operational policy necessary to implement Title 32 to the Code of Federal Regulations Part 199 (32 CFR 199). This manual augments the 32 CFR 199 and must be used in conjunction for complete policy information." How are we to treat inconsistencies between the Policy Manual and 32 CFR, Part 199 having to do with authorizations?

RESPONSE: Please provide the specific inconsistencies to which you are referring.

627. Section L .12.f. (2)(b), "Past Performance Information", specifies that "The offeror shall provide a narrative that describes experience…in performing work that is relevant to this solicitation". ***-but-*** Section M.7.b., "Evaluation of Past Performance/Performance Risk", specifies that "The Government will evaluate past performance as it relates to fulfilling the *functional requirements of all elements in Section C…"* (Italics added for emphasis).

Please define "functional requirements of all elements in Section C". Given the page limit of 25 pages for the Past Performance Volume, and the 10 pages of C-7, "Technical Requirements", please clarify to what level the offeror must report Past Performance vis-a-vis Section C. Is it necessary to discuss every " C" requirement as it relates to Past Performance?

RESPONSE: ***revised 8 October, 2002***

RESPONSE: In a future amendment, we will delete the reference to Section C and the first sentence will read: "The Government will evaluate past performance relevant to this solicitation."

628. In the TRICARE Operations Manual 6010.51-M, August 1, 2002, Chapter 4, Section 1, it states that "Network Providers shall be credentialed in accordance with nationally accepted credentialing standards adopted by a national accrediting body". Is the intent that whatever accrediting body the contractor chooses to use, those standards will be acceptable to the government unless there is a higher standard noted in the regulations?

RESPONSE: Your interpretation is correct.

629. The TRICARE Operations Manual, Chapter 5, paragraph D.1.c and enclosure 3 of Addendum A, address "Preselection Criteria for Healthcare Practitioners". Please confirm that the criteria in enclosure 3 apply only to providers who will be granted staff appointments and clinical privileges within the direct care system. The enclosure 3, paragraph M requirement for an FBI background check is not required today for providers in the MCS contractor's network. If it is understood that these Preselection Criteria are NOT for use in credentialing the contractor's network providers, is it again reasonable to assume the contractor can credential using criteria from a national accrediting body?

RESPONSE: The referenced criteria are for providers practicing in the MTF. Again, we confirm your assumption that the accrediting body criteria apply unless more stringent criteria exist in the regulation.

630. Who funds the non-healthcare cost component of resource sharing agreements - the MTF or some other entity?

RESPONSE: See L15. The expected no-health care costs for resource sharing are to be included in the administrative price which is proposed.

631. Please provide a list of all existing resource sharing agreements in all three regions. Please include the location of the agreement (MTF), the specialty type (i.e. Primary Care, Urology, etc.), the number of physician providers, the number of non-physician clinical providers (i.e. nurses, physicians assistants, etc.), and the number of non-clinical staff (i.e. clerks). In the absence of any specific data elements, please provide as much information as possible.

RESPONSE: Available data was provided in Amendment 2

632. Reference Section F.4 of the RFP - Please verify that no Regional boundary changes were intended by the consolidation of the existing Regions into the MCS Contracts for the North, South, and West. (NOTE: In addition to the clarification already provided currently for certain Non-Catchment zip codes in Texas related to Cannon AFB to remain in the Central (West for the RFP) Region, are the 80 Iowa zip codes adjacent to Rock Island Arsenal still considered to be Region 5, rather than Central?)

RESPONSE: Verified. Yes, the 80 Iowa zip codes adjacent to Rock Island Arsenal are in Region 5.

633. Reference Section C-7.1.3 and Attachment L-1 - In regard to TRICARE eligibles only, and excluding TRICARE Prime Remote (TPR) Active Duty Family Members (ADFM), does the Government require that the subsequent MCS Contractor continue to offer Prime enrollment to beneficiaries not residing in Prime Required (Catchment, BRAC, and other Government designated) areas?

RESPONSE *Revised October 21, 2002*

RESPONSE: Yes

634. If the subsequent MCS Contractor chooses to maintain Prime enrollment in non-Prime required areas, does this voluntary action cause Prime requirements and applicable Performance Guarantees to be invoked?

RESPONSE: Yes

635. The Government no longer requires the use of its TRICARE ClaimCheck software package. However, since one vendor (McKesson) effectively controls the most commonly used commercial "unbundling software," this apparent relaxation of requirements will likely increase administrative costs and dissatisfaction in the following ways:

a. Provider and beneficiary satisfaction will be impaired as the three MCS Contracts, foreign claims, and the TDEFIC will likely all have different software or customization concepts.
b. Very favorable Government software usage and maintenance pricing is eliminated.
c. Bidder specific "unbundling software" will lead to increased implementation and maintenance costs with the claim processor. Please explain the "benefits" of breaking the relationship with the current "unbundling software" vendor?

RESPONSE: We understand your comments; however, we do not believe that increased costs will exist. In fact, this relaxation of the requirement is one step toward increasing competition as only the incumbent contractors have the current system. Second, we do not believe that additional dissatisfaction will result as providers will not be familiar with the claims adjudication processes of all three regional contractors and beneficiaries are primarily interested in their out-of-pocket expenses which are based on the program they elect to utilize (prime, extra, or standard). With this in mind, accurate adjudication of claims will not alter the beneficiaries out-of-pocket expenses. We also believe that MCSCs, using their commercial processes, will have the purchasing power to equal or exceed the discounts achieved by the Government. In summary, implementing best practices will increase competition without increasing cost of dissatisfaction.

636. Reference Section H, H-1.a.(1), and H-1.b.(5)(b) of the RFP - Please clarify whether the Contractor Financial Underwriting of Healthcare Costs includes or excludes MTF At Risk claims?

RESPONSE: Includes

637. What Government prepared claims-based TEDs reports on an ongoing basis are available for the MCS Contractors to monitor the various claims standards subject to Performance Guarantees? NOTE: The bidder wants to ensure that it has the "same

view" of TEDs activity as the Government, so any needed action can be implemented in a timely manner.

RESPONSE: TEDs are submitted by the contractor for editing by the Government. The Government will provide monthly TED reports that indicate the TMA calculations and the data used in the calculation only for those performance standards that the contractor fails to meet.

638. Does the Government intend that the MCS Contractor fully fund all underwritten healthcare costs (Contractor At Risk and MTF At Risk) until processed claims have been accepted by TEDs (Contractor At Risk) or reimbursed by the MTF based on invoices (MTF At Risk)? There is no Commercial precedent. NOTE: In commercial insurance: [a] Underwritten healthcare costs are funded in advance through the payment of premiums. [b] Administrative Services Only (ASO) healthcare costs are funded by the entity (i.e., the Government) as claims are paid.

RESPONSE: Yes, the MCSC funds the cost of health care until reimbursed by the Government.

639. Item-Document 11, Description-Military Treatment Facility, Direct Care DAta, DEERS Population Data, TRICARE/CHAMPUS Purchased Care Data, T-NEX Reference Files. Where are the items located?

RESPONSE: Please refer to Section L-13f.(4) "The Cost Proposal" under paragraph (b). You must purchase the data tapes in order to receive this information.

640. At the preproposal conference you stated there would be no specific credentialing requirements. This is based on the network being accredited by one of the accrediting agencies; NCQA, URAC, or JCAHO. However, in the Tricare Ops Manual, DOD 6010.51-M dated August 1, 2002, there are specific requirements that exceed the standards promulgated by NCQA and URAC. For example, reappointment every two years, both NCQA and URAC permit a 3 year recredentialing cycle. Also, collection of work history or practice experience for all periods of time back to graduation. NCQA only requires 5 years of work history. There is also a requirement for Peer References, which is a JCAHO requirement, but not a requirement for the other accrediting agencies. We need clarification of these issues, to clearly understand what the credentialing requirements for network providers will be.

RESPONSE: We believe you are reviewing the TOM, Chapter 5, Addendum A and that Addendum will be removed in a subsequent amendment. What the Government requires in the solicitation is in Section C-7.1.1. "The contractor's network shall be accredited by a nationally recognized accrediting organization no later than 18 months after the start of health care delivery in all geographic areas covered by this contract. When this contract and the accrediting body both have standards for the same activity, the higher standard shall apply."

641. Amendment 1 to the RFP deleted the contract line items from Section B for the Continued Health Care Benefit Program (CHCBP). However , section C-7.21.15 still requires contractors to manage enrollments, collect premiums and pay claims for CHCBP. Is this still a requirement? If so, how are contractors to reflect the costs of administering this program in Section B?

RESPONSE: Continued Health Care Benefit Program (CHCBP) is still a requirement. The costs shall be proposed under the respective Per Member Per Month line items.

642. Upon review of the TRICARE Operations manual (August 1, 2002), it is noted the requirement for an unmanaged 8 sessions for mental health outpatient treatment has been removed. In addition, there is no requirement for this in the solicitation MDA906-02-R-0006. There is a remaining reference to these 8 sessions in the TRICARE Policy Manual (August 1, 2002). Since the unmanaged 8 sessions significantly limit the contractor from meeting objectives 1, 2 and 3 of the solicitation (and in addition could be a significant, uncontrollable cost to the MTFs under alternative financing), was it an oversight to have not removed this language from the Policy Manual?

RESPONSE: The Policy Manual will be corrected in a future Amendment to eliminate the requirement of 8 non-authorized mental health sessions.

643. The new Systems Manual has excluded the provisions found in the old manual (Chapter 1, Section 3.8) that states that TMA will only reimburse contractors for initial submission of claims. Based on this exclusion, it appears that contractors will be reimbursed for adjustments made to original claims on a claim rate basis. Please confirm.

RESPONSE: Claim Rate Payments: TMA will not pay a claim rate for adjustments to claims. The contractor shall receive one claim rate payment based on an accepted TED ICN. However, if as a result of the adjustment, a claim that was previously rejected but a claim rate payment is now payable, a claim rate will be paid. (occurs automatically, still one payment per ICN)

Benefit Payment Reimbursements: Benefit payments/reimbursement shall be paid to the contractor upon acceptance of a TED record. Adjustments to government paid dollars (benefits only) on a previously submitted TED record must be done under a new voucher header adjusting original TED ICN. The incoming adjusting TED record shall only include the dollar amount(s) needed to adjust the original TED record to the correct value. The Contractor shall receive payment/collection of benefit dollars reported under a new voucher header upon acceptance of adjusted TED record.

644. Please confirm that it is the Government's intent to exclude all Medicare and TRICARE eligible beneficiaries regardless of age as far as claims processing under this contract. Also, please indicate if this is also true for active duty dependents who are also eligible for Medicare. The T-Nex draft for the TRICARE Dual Eligible Fiscal Intermediary contract states in C-3.2.4.1, "The contractor's claims processing/encounter system shall accurately process claims in accordance with the program authorizations (e.g., PFPWD, inpatient mental health, outpatient mental health visits greater than 8, adjunctive dental, etc.) received from the Managed Care Support contractor." We assume that this means we will be sending a HIPAA 278 transaction to the Dual Eligible contractor to accomplish this. Please confirm if this is correct.

RESPONSE: Except for claims from overseas sent to the South Contractor, all Medicare/TRICARE eligibles will be excluded from this contract regardless of age. This also means Active Duty dependents who are eligible for Medicare are excluded also. No, you will not be sending any HIPAA 278 transaction to the Dual Eligible contractor; this draft statement has been eliminated.

645. L-15 (per Amendment 1) states, "For the purposes of this solicitation, neither offerors, nor the Government, shall assume any resource sharing savings in purchased-care dollars in conjunction with the development of option period I target costs for the contract. The successful offerors and the Government may negotiate resource sharing agreements as a tool that may be used by both parties to reduce purchased-care and overall underwritten expenditures." Given that offerors are prohibited from assuming any savings from resource sharing, we assume that we will need to remove the current savings from the baseline evaluation. As such, what will the Government be providing to the offerors to properly adjust the baseline health care dollars listed on the data tapes to ensure that no savings are bid for the current resource sharing projects?

RESPONSE: The language you have referenced has been removed by amendment. Please review Amendment 2 and make any assumptions you deem necessary.

It is important to differentiate between "old" resource sharing agreements and "new" agreements. "Old" agreements are defined as those Resource Sharing agreements in existence today through the existing MCSCs. "New" resource sharing agreements are those that may come into existence under this solicitation (agreements after April 1, 2004, under "new" MCS contracts).

"Old" agreements will terminate when the existing MCS contracts expire. The Government has provided data on these agreements. The Government has also examined the value of these agreements and where these "old" agreements have value, TMA is providing the Surgeons General with the money to continue these "old" agreements through other means. Other means includes, for instance, direct contracting. It excludes "new" resource sharing agreements.

Thus, for bidding purposes, offerors must make an independent assessment of the value of "old" resource sharing agreements in terms of their impact on historical costs and, depending on the offeror's bidding strategy, include some, all, or none of the historical "old" resource sharing workload (and associated costs) in their proposal.

Offerors are not to include cost shavings that may result from "new" resource sharing agreements. This is because the Government will not commit to any savings occurring as a result of "new" resource sharing agreements nor will the Government commit to implementing any "new" resource sharing agreements. The reason the Government will not commit to "new" agreements during the fist option period is two fold. First, we have learned from the old MCS contracts that commitments on an individual MTF-by-MTF basis may only be made by the MTF Commander and then only after careful analysis and consideration. Accepting proposals with high level information does not fulfill the Commander's appropriate responsibility to analyze each potential "new" agreement. As such, no Government commitment is appropriate at the regional proposal level. Second, the Government believes that very little, if any, opportunity for "new" resource sharing savings exists in Option Period 1. This is because the productivity and associated savings that have resulted from "old" resource sharing agreements have identified and achieved the significant savings that can be attributed to resource sharing in the short term. Second, the time required to identify a "new" resource sharing opportunity, develop the data, conduct a comprehensive analysis, achieve agreement and approval, and hire the resource will require the majority of, if not all, option year 1.

646. The data tapes provide incomplete information on TSC workload regarding the number of referrals processed, telephone calls received, telephone lines, healthcare finder authorizations, and walk-ins. While we appreciate the Government's effort to query the existing contractors to obtain this information in order to share it with all potential offerors, it appears that some incumbents provided more complete information than others. Without this information being made available to all, the incumbent contractor responsible for the affected TSCs that did not disclose the information will have a competitive advantage. How does the Government propose to supply the missing information in order to level the playing field for all potential offerors?

RESPONSE: The Government has furnished an updated TSC data set to those entities who have purchased the data tapes. This data, however, only represents data that is available to the Government. While we recognize that an incumbent contractor may have additional proprietary data, we do not believe that this necessarily represents an advantage. This is because the work required under these contracts is significantly different from the existing contracts and because the work generated through existing contracts is, to a degree, a product of the current contractor's performance. For instance, current contracts require significant amount of care to be preauthorized. The contracts you a bidding upon require offerors to propose their best practices. These could well vary significantly. Also, the current contracts include pharmacy and TFL services. The contracts being bid upon exclude these services, yet, they continue to require a high level of service to these populations when the information is available to the MCSC contracts. These examples serve to demonstrate that offerors may be best served by examining the requirements of this contract, their model for delivering services and projecting their workload independently.

However, even if some of the information retained by the incumbents provides some advantage, it does not rise to the point of being unfair. For example, all incumbents interface with MTFs concerning health care operations. The RFP's requirements clearly require on-going MTF interface through its objectives, in particular optimization and best-value health care. We would not expect the incumbents to provide data (for inclusion in the RFP) concerning the actual costs (staffing, overhead, etc) they have incurred in working with the MTFs. This knowledge clearly constitutes some form of competitive advantage; however, it is proprietary information, of a nature inherent in incumbency.

a. In addition, the data provided does not address workload (number of referrals processed, telephone calls received, telephone lines, healthcare finder authorizations, and walk-ins) at all off-site locations, such as TSCs on commercial properties or closed call center/processing centers. Once again, those who have not shared this information will have an unfair advantage since only they have knowledge of this workload. How does the Government propose to supply the missing information in order to level the playing field for all potential offerors?

RESPONSE: In the TSC update that was provided, all information available to the Government was provided. See above answer.

647. L-12.f.(2)(d)requires the offeror to submit a Past Performance Report for each of the offeror's top five overall accounts. Will submission of the annual CPAR for an incumbent Managed Care Support contractor meet this requirement, or is the

incumbent required to submit a Past Performance Report (Attachment L-4), signed by the Contracting Officer?

RESPONSE: The submission of the CPAR is not to be submitted and would not meet this requirement as we are looking for different information than in CPARs. The Government will extract that information from the Past Performance Information Retrieval System. The incumbent is required to submit a Past Performance Report (Attachment L-4) signed by the Contracting Officer if the TRICARE contract is one of the 5 accounts by gross revenue.

648. The claims data tapes provided by the government for the Southeast Region include processed claims for MCS contracts in the Central Region, Unisys Health Information Mgmt., MCS Region 2/5, MCS Region 1, and MCS Regions 9, 10, and 12 (based upon the Contractor Number Code field). Could you please explain why these claims are included with the Southeast Region data.

RESPONSE: The data files for the regions are based on the beneficiary address regardless of where they are enrolled. Enrollment location doesn't matter. Beneficiaries residing in the SE region but enrolled in another region would be included in the SE region data, with a contractor number other than that expected for the SE region. (There should be no Unisys claims.) However, there were several unique requirements for specific types of data to be included in the SE region. For example, all CHCBP claims were included only in the SE region even though currently a variety of contractors are be responsible for processing these claims. There are also some records for people living abroad, eligible for TFL, who will not be included in the next "Dual Eligibles" contract. Care for these beneficiaries could have been processed by multiple MCS contractors, depending on the region where care was rendered, and thus will be considered as part of the SE contract.

649. Reference: Section F.4.(b) - in the last sentence the Government states: "The contractor shall be responsible for....fulfilling the overseas requirements of the European, Pacifica and Latin American / Canada regions." In the Government's response to Question # 3, the Government stated, in part, "When the new MCS contracts are implemented, the current seven MCS contracts covering 12 CONUS and 3 OCONUS regions will be consolidated into three contracts..."

a. Are OCONUS regions included in the MCS South Region contract solicitation? Please provide details.

RESPONSE: The South contractor will process claims received for care rendered in foreign countries and the U.S. territories. Other services are also required and the detail is in the Policy Manual, Chapter 12. These are the only services the South contractor is required to supply. The regional structure will remain the same for OCONUS and the overseas Regional Directors are independent of the CONUS Regional Director in the South Region.

b. What specifications apply to the overseas requirements in the 3 OCONUS regions - Europe, Pacific, Latin Ameria / Canada?

RESPONSE: See the response to Question 649a.

c. What is the transition schedule for the OCONUS Regions to be shifted under the MCS South Region?

RESPONSE: The transition schedule for OCONUS claims process and other activities defined in the Policy Manual, Chapter 12 with occur with the transition of the current Region 3.

650. Prior contracts have included provisions applicable to circumstances of war, or acts of war, whether declared or undeclared, which modify the contractor risk under the contract. Will such provisions apply to this contract and, if so, will similar modifications result for terrorist actions?

RESPONSE: The current provisions in the MCSCs, "Contingencies for Mobilization" applies to full mobilization. In the case of full declaration of war, we anticipate that the contracts will be modified to take into the account the potential of all MTF family member enrollees reverting to the network. What form that modification would take we are not prepared to say but anticipate working the contractors during a potential "ramp up" of the contractor's activities. No modifications are anticipated for terrorist actions; however, the contractor always has the right to request an equable adjustment.

651. Section G-5 provides for the adjustment of administrative cost payments due to changes in member months. The Government acknowledges that changes to membership will result in changes in administrative cost, and provides an adjustment mechanism to account for those cost changes. However, we do not observe such an adjustment to account for the change in health care cost due to increases or decreases in members. Do we understand this correctly? If so, why is there no similar mechanism for adjusting health care costs?

RESPONSE: Once the target cost for a given option period is set through the negotiation process, the target for that option period is not adjusted for changes in eligibles. However, the 80-20 "fee curve" relationship for determination of realized fee means that the contractor still automatically receives protection for 80 percent of the health care cost impact of eligibles changes that occur in that option period. The recent actual eligibles experienced can also be considered when negotiating the next year's target cost. Finally, in the event the fall-back formula is triggered to set the target cost for a given option period retroactively (because negotiations did not succeed by the mandated deadline), then the national trend factor used in that formula would implicitly include the effect of the national trend in eligibles that year, although not a region-specific eligibles effect. See also the answer to Question 397.

652. By carving out Medicare dual eligible claims processing, Medicare eligible members will not have the cost advantage from TRICARE contractor networks. Is this the government's intention or do you have another option in mind that will continue the access to discounts?

RESPONSE: Dual eligibles will not have access to the discounts.

653. Due to the significant improvement in TRICARE benefits there has been a significant increase in induced demand and the return of "ghosts" to dependence on TRICARE as their primary coverage. Since the government provided experience data cuts off in Sep 2001, the significant cost increase will not be included in the base as bidders complete their cost proposals. This can lead to underestimation of the target healthcare costs for year 1. Will the government provide more current

claims experience with completion factors so that all bidders fully understand this acceleration of trend?

RESPONSE: Yes. The Government's updated the FY02 HCSR detail tapes on September 16, 2002. That included all HCSRs accepted at TMA through August 2002.

654. The RFP directs the contractor to ignore any savings potential for resource sharing in their bids. However, experience data only includes the cost of Resource Sharing initiatives. If these are not renewed, then the savings, which can be two or more times the cost, will not be achieved, resulting in a significant growth in actual healthcare costs. Request that the government update the experience data to include the delta between the cost of Resource Sharing and the net savings being realized and provide bidders with guidance on how this difference should be considered in their bid?

RESPONSE: We understand your request; however, the Government will not be making projections of this nature.

655. When the government collects beneficiary and MTF commander satisfaction results in relation to the award fee, can the government report the result of those surveys by state or catchment area to the contractor to aid in assessing and assigning subcontractor incentives?

RESPONSE: The Government will not commit to such reporting to the contractor. The Regional Director may elect to provide survey information to the contractor.

656. Regarding l -2 Regional Descriptions - South Region: The last paragraph states "In addition.....and fulfilling the overseas requirements of the European, Pacifica, and Latin American/Canada Regions". Please explain in detail the requirements in these OCONUS areas.

RESPONSE: The overseas requirements are found in the Policy Manual, Chapter 12.

657. Is the use of a third party contracted provider network acceptable in the case where an offeror does not currently maintain its own provider network in part of the region for which it is offering a solution?

RESPONSE: That is acceptable.

658. According to the TRICARE Operations Manual 6010.51-N, August 1, 2002, Chapter 4, Section 1: Network providers shall be credentialed in accordance with nationally accepted credentialing standards adopted by a national accrediting body. Network accreditation agencies (URAC and NCQA) require recredentialing of individual providers every three years. There is no required timeline noted in Chapter 4. However, there is a reference in Chapter 5, Addendum A in section D.1.d.(3) that reappointment shall occur at least every two years. Does the solicitation then require recredentialing of network providers every two years?

RESPONSE: The TOM, Chapter 5, Addendum A will be deleted in a future amendment.

659. Answers to questions 102 and 192 try to clarify the requirement for a single system versus a single data base. Is there a definition of what TMA considers a single system to be? In the TRICARE environment today, many systems are integrated to administer the TRICARE benefit. The sheer volume of claims in any of the new regions being administered real time may necessitate multiple systems.

RESPONSE: No, there is no definition. What we want to avoid is the scenario in which several different software packages are used to process claims leading to inconsistent results within the region.

660. Months of Health Care Cost **-** In the West Region procurement, the government will ultimately be purchasing 60 months of healthcare in the former Region 11, 57 months in former Regions 9, 10, and 12, and 54 months of healthcare in the former Central Region. However, in the evaluation of the healthcare, the government is only considering 12 months, 9 months, and 6 months, respectively, from these three sub-regions. The amount of healthcare evaluated in each sub-region is therefore not proportionate to the amount of services which the government will ultimately be purchasing. We do not believe that this is consistent with an objective of evaluating costs which reflect the government's expected costs. We suggest that, for the government to appropriately analyze the healthcare risk it is taking by region with each contractor, an adjustment be made to reflect the actual amount of healthcare purchased. While there are number of ways this could be accomplished, we would suggest that the evaluated health care costs for each sub-region be increased by the ratio of the ultimate number of months to be purchased over the number of months evaluated and then divided by five to make each a one-year value. Thus, for sub-region 11, the formulae would be: [60 months divided by 12] divided by 5 (which equals 1) times evaluated health care costs. For sub-regions 9, 10 and 12 this would then be [57 months divided by 9] divided by 5 (which equals 1.267) times the 9 months of evaluated health care costs. Lastly, for the sub-region Central this would be [54 months divided by 6] divided by 5 (which equals 1.8) times the 6 months of evaluated health care costs. This would result in a consistent weighting of the evaluated health care and the costs of the care ultimately purchased by the government. This would remove any unfair bias in the evaluation of health care costs for or against any one contractor based upon their strengths or weaknesses within any sub-region.

RESPONSE: The Government does not share the offeror’s opinion that an “unfair bias” might exist in evaluating only the Option Period I target health care costs. The RFP will not be changed to account for the phased-in geographic areas being less than one year of health care services delivery. Offerors are reminded to follow the instructions in the RFP. The Option Period I target costs shall include applicable estimated health care costs for the various number of months of health care that each respective geographic area contributes to the total for Option Period I.

661. Electronic Proposal Submission **–** The RFP L.11.e. requires submission of the proposals on CD-ROM, except for documents previously printed that are to be submitted in hard copy. Would the Government accept scanned copies of previously printed material for electronic submission in PDF format?

RESPONSE: Yes, that would be preferred.

662. Specialty Care Referral/Consultation/Operative Reports **-** H.8.m. Specialty Care Referral/Consultation/Operative Reports states the following: "Standard: The

contractor shall ensure that network specialty providers provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiary's primary care manager within five working days of the specialty encounter 98% of the time. In urgent/emergent situations, a preliminary report of a specialty consultation shall be conveyed to the beneficiary's primary care manager within one hour by telephone, fax or other means with a formal written report provided within the standard. All consultation or referral reports, operative reports, and discharge summaries shall be provided to the primary care manager within 30 calendar days.

"A performance guarantee shall be applied as follows for visits failing the standard: Based on the contractor's monthly report, a performance guarantee amount of $100 for each report not provided timely will be withheld. For example, if 97% of reports are provided within the standard, and 100 reports were required, the Government will withhold $300 ($100 x 3 missing/late reports)."

The example above explains how the 100% standard in 30 days would be applied. In the 100 reports example above, is it true that if 97 reports were returned in 5 days or less, a $100 performance guarantee would be assessed? Is it further true that if these same three reports were still outstanding at the 30 day point, the performance guarantee would be $200 since $100 had already be paid on the five day standard totaling the $300 performance guarantee used in your example? Is this correct, and if not, what is the accurate interpretation of the requirement?

RESPONSE: Your interpretation is correct. As mentioned in other answers, a future amendment will change the time frames from 5 working days/1 hour to 10 working days/24 hours.

663. Attachment 8 to Section J, states that the T-NEX Reference Files contain PRIME non-catchment area zip codes. Does the Government require offerors to continue offering TRICARE Prime in all of these non-catchment areas?

RESPONSE: No. However, the contractor is free to propose additional Prime sites (Section C-7.1.3).

664. Reference RFP Section J, Attachment 8, Data Tapes. The data provided on TSCs [Spreadsheets Q5_PartA_3Jul02.xls and Q5_PartB_3Jul02.xls] appears to be incomplete The Part A spreadsheet has 186 TSCs while the Part B spreadsheet has only 162 TSCs. Also, some TSCs appear to be missing (for example, Blytheville, AR or Alexandria, LA). The spreadsheets do not include workload data for centralized service centers. Will TMA provide all of the needed information for all service centers?

RESPONSE: The Government has furnished an updated data TSC data set to those entities who have purchased the data tapes. This data will contain all the information available to the Government.

665. There are two items we would like clarified in reference to the requirement "the contractor shall ensure that network specialty providers provide clearly legible specialty care consultation or referral reports… to the beneficiary's primary care manager within five working days of the specialty encounter 98% of the time".

a. It is assumed that for behavioral healthcare treatment a report would be required for each referral and not for each "encounter". For behavioral healthcare services, every specialty encounter could be as frequent as 2x per week over the course of a year or more. As such, if a report is submitted after each visit, there would be an extensive paper trail for review, and oftentimes there would be little change to report on the patient's progress.

RESPONSE: You are correct, the treatment report would be required for a referral. Best medical practices would dictate the frequency of progress reports.

b. It is also assumed that reports would not be expected for care that is self-referred, as the contractor will have no way of knowing that care is being rendered or received. Research shows that treatment for outpatient mental health is typically completed in less than 8 visits per episode of care. Therefore, these cases would not be reported to the primary care managers.

RESPONSE: There are two issues here. First, reports are only required based on referrals. However, network providers must recognize the importance of coordinating a patient's care and act in the best interest of the patient.

666. Be advised that the MCSS Solicitation Questions and Answers posted on September 6th did not include #460 thru #499.

RESPONSE: The list of questions were renumbered on the web site to correct this oversight.

667. The question set posted on Septebmer 6, 2002 appears to have a numbering problem. The question set skips numbers 460 to 499. Please advise if there are questions missing in the report or if there is simply a numbering error.

RESPONSE: The list of questions were renumbered on the web site to correct this oversight.

668. Reference RFP Section J, Attachment 8, Data Tapes. The data provided on TSCs [Spreadsheets Q5_PartA_3Jul02.xls and Q5_PartB_3Jul02.xls] appears to be incomplete The Part A spreadsheet has 186 TSCs while the Part B spreadsheet has only 162 TSCs. Also, some TSCs appear to be missing (for example, Blytheville, AR or Alexandria, LA). The spreadsheets do not include workload data for centralized service centers. Will TMA provide all of the needed information for all service centers?

RESPONSE: Please see the answer to Question 664.

669. In the RFP, Section C-7.11 indicates "the contractor shall use the TRICARE Enrollment and Disenrollment Forms listed as Attachments 2 and 3 in Section J". An answer to question number 323 indicates the contractors must bid on the form as written. The following issues with the form will have a cost and negative customer service impact, therefore, we request a review and response to the following questions:

a. Since the enrollment/change form does not have a box for the beneficiary to select the portability/transfer option, and the processing timeframe for portability applications is within four work-days of receipt (OPM, Chapter 6, Section 5, 1.5),

does this mean all applications and change forms must be processed within four work-days of receipt?

RESPONSE: The current Operations Manual 6010.49M is not a requirement of this contract; the correct reference is the TRICARE Operations Manual 6010.51-M, Chapter 6, Section 2.1.5. No, there is no time requirement to process the initial enrollments or changes but form received on or before the 20th of the month must be process and the enrollment effective at the beginning of the next month (TOM, Chapter 6, Section 7.1). If your concern is to identify transfer enrollments, when the beneficiary is physically present to submit the enrollment the contractor should ask the beneficiary if this is an initial enrollment or a change. Other methods of identifying transfers are left to the offeror's proposed procedures.

b. The response to question number 171 indicated the contractor would use the enrollment/change form for TRICARE Plus. The completion and submission (to the MCSC) of all Plus enrollment/disenrollment forms are now administered by the MTFs, will this process stay the same?

RESPONSE: The process will stay the same. What was meant by that answer was that the TRICARE Plus will use the same forms and if asked for a form by a potential Plus beneficiary at the TSC, that form should be provided. The MTF shall continue to manage the TRICARE Plus program but the contractor is still required to data enter the enrollments in DOES.

b.1. If not, will the form's mailing instructions be changed to prevent the applications from being misrouted and the beneficiary enrolled in the wrong Health Care Delivery Plan?

RESPONSE: See above response.

b.2. Will the form's instructions be modified to include information to let the Plus enrollees know they should not complete Section VI, which requires fee information?

RESPONSE: We believe the instructions are clear. This applies to Medicare eligibles under 65 years of age which are still allowed to enroll in Prime. If a retiree has Medicare Part B enrollment fees are waived. Therefore, they need not fill out the Section VI on payment options.

670. In Section VI on the enrollment/change form, indicates "Retired beneficiaries enrolled in Medicare Part B may have their enrollment fee waived if they provide a copy of their Medicare card as proof of enrollment in Medicare Part B." Is the contractor to coordinate with DEERS to get DEERS updated with this information?

RESPONSE: If DEERS does not show the beneficiary as enrolled in Medicare Part B but the beneficiary has provided a copy of their Medicare card as proof of enrollment in Medicare Part B, the contractor should advise the beneficiary to contact the DEERS Support Office at the beneficiary-only number to ensure that DEERS is updated with the correct information.

a. If not, is the contractor to accept the Medicare card copy as proof and enroll the beneficiary regardless of status on DEERS?

RESPONSE: The contractor shall not accept the Medicare card copy as proof and enroll the beneficiary if DEERS does not show the beneficiary as enrolled in Medicare Part B. If DEERS does not show the beneficiary as enrolled in Medicare Part B, the contractor should refer the beneficiary to the DEERS Support Office to have their records updated.

b. The enrollment/change form does not include any information to notify the beneficiary that the first payment must be a full quarter's payment (OPM, Chapter 6, Section 1, 8.1) and when the monthly allotment and electronic funds transfer process will be established. The form's current format does not support the OPM requirement, will the form's instructions be revised to clearly indicate the payment requirement?

RESPONSE: Yes, the enrollment form instructions will be revised. The revised instructions will inform the beneficiary that when establishing monthly allotments or Electronic Funds Transfers (EFTs), an initial fee payment of three months must be collected at the time of enrollment or re-enrollment. The purpose of collecting a three month fee in advance is to permit adequate time for the allotments or EFTs to be established. It is expected that monthly allotments and EFTs will begin on the first day of the fourth month following enrollment or re-enrollment.

c. If not, what is the contractor's requirement for processing when receiving only one month's payment with the initial enrollment?

RESPONSE: The enrollment form instructions are being revised. The enrollment information package will describe the requirement for an initial fee payment of three months when establishing monthly allotments or EFT payments. It is the contractor's responsibility to request and receive payment for the three months when the monthly payment option is selected. The contractor shall not enroll a beneficiary under monthly allotments or EFTs without collecting the initial three month enrollment fee.

671. Number 8 of the general instructions indicates that if the beneficiary is requesting a PCM change within the same MTF, the form is to be submitted to the local MTF. TRICARE Systems Manual, Chapter 3, Section 1.5, 1.2.5.1 indicates PCM by name processing will occur using the DOES application. Will the instructions be modified to reflect the system's requirement?

RESPONSE: Yes, the instructions are being revised to have requests for PCM changes submitted to the T-NEX MCSC contractors instead of the local MTFs.

672. OPM Chapter 6, Section 1, 8.1 indicates the Prime enrollee shall select one of the three payment options on the Prime Enrollment Application. Is this the mechanism to be used to allow existing enrollees to change their payment option? If so, please explain when (renewal time or other) this is to occur.

RESPONSE: Yes, at the option of the beneficiary the payment option can be changed any time.

673. OPM, Chapter 6, Section 1, 9.1 indicates the contractor shall provide a paper and an electronic process to enroll, but, TRICARE Systems Manual Chapter 3, Section 1.5, 1.2.3 indicates DEERS will NOT provide support or interfaces to contractor's web applications that perform any enrollment-related function. Will the use of the DEERS

web application for beneficiaries to perform most enrollment functions meet the requirement?

RESPONSE: Yes. For TRICARE enrollments, the DEERS enrollment web application is the application that will be used. It meets the requirement for contractors to provide an electronic process to enroll since contractors will be required to act on enrollments submitted through the DEERS enrollment web application. DEERS will not provide support for or interfaces to contractor developed enrollment web applications.

674. TRICARE Systems Manual Chapter 3, Section 1.5 indicates the enrollment function performed on the DEERS web application will be in a pending status awaiting acknowledgement by the contractor – how will the contractor be notified of the pending enrollment? If there are any issues, problems with the enrollment that prevent the enrollment or alter choices made by the beneficiary, what follow-up requirements does the contractor have?

RESPONSE: The contractor will be notified of "pending" web enrollments via Enrollment Interface Transactions (EITs). The contractor is expected to review and acknowledge all "pending" web enrollments in DOES within four calendar days. The contractor shall contact the beneficiary, if necessary, to resolve any discrepancies in the web-submitted application. If for some reason the pending web enrollment is not accepted, the contractor is required to send an explanatory letter to the beneficiary within five calendar days from the date the web enrollment was submitted by the beneficiary. Also, if the web enrollment is not accepted, the contractor shall also cancel the enrollment using DOES.

675. TRICARE Systems Manual Chapter 3, Section 1.5 indicates the beneficiary will be able to perform several enrollment functions. Will the web application have the MTF assignment restrictions built into the process? Additionally, what other edits will the beneficiary encounter when performing the enrollment function?

RESPONSE: The DEERS web enrollment application will contain edits and checks for beneficiary eligibility and hard edits requiring the beneficiary to fulfill established DEERS business rules and enrollment criteria. To the extent possible, the web application will incorporate common MTF assignment parameters, however the contractors must review the pending web applications for consistency between PCM selection requests and specific MTF commander requirements.

676. Section L-13.e(4)(o)(4) states that "offerors shall explicitly identify their assumptions regarding the number of MHS-eligible beneficiaries reflected in its proposed target healthcare cost." Offeror's are responsible for health care costs of non-TRICARE/Medicare Dual Eligible CHAMPUS beneficiares, not MHS-eligible beneficiaries. Should this statement refer to assumptions regarding the number of CHAMPUS-eligible beneficiaries, since the contractor is responsible for the health care cost of these beneficiaries, not MHS-eligible beneficiaries? If indeed our assumption is correct, then it appears that this call for assumptions is a repeat of L-13.e(4)(o)(3). If this is not correct, please clarify the intent of this requirement, and explain the effect of MHS-eligible beneficiaries on health care cost.

RESPONSE: The offeror's assumption is correct; target health care costs are to be estimated based on the offeror's projected number of non-TRICARE/Medicare dual-eligible CHAMPUS beneficiaries. Section L of the RFP will be amended to correct this.

677. Question #30. RFP Section C-7.12. & C-&.15. pages 27 & 28, Will beneficiaries currently enrolled to a network PCM under the present contract be required to transfer enrollment to an MTF PCM if capacity exists at the start of the new contract or anytime during the term of the new contract? (Received 16 August 2002)

RESPONSE: ***revised 20 September 2002***

RESPONSE: In an upcoming amendment, Section C-7.15. will be changed to read, "If a beneficiary's civilian primary care manager remains in the TRICARE network, the beneficiary may retain their primary care manager. If the beneficiary must change primary care managers, all enrollments shall be to the MTF until MTF capacity, as determined by the MTF Commander, is reached.

678. Question 376. Section C-7.15 of the RFP requires the incoming contractor to enroll all Prime beneficiaries to their assigned PCM. If a beneficiary was enrolled to a civilian PCM with prior contractor, will they need an exception from the MTF Commander as described in section C-7.12?

RESPONSE: ***revised 20 September 2002***

RESPONSE: In an upcoming amendment, Section C-7.15. will be changed to read, "If a beneficiary's civilian primary care manager remains in the TRICARE network, the beneficiary may retain their primary care manager. If the beneficiary must change primary care managers, all enrollments shall be to the MTF until MTF capacity, as determined by the MTF Commander, is reached."

679. In reviewing the latest updated list (9/9/02) of questions and answers I noted that questions 460-499 are missing from the document. Just thought you'd like to know. I assume they'll reappear in the next update.

RESPONSE: The list of questions were renumbered on the web site to correct this oversight.

680. In the 9/9/02 issue of Q&As, the response to Q 21.f. identified the cities were the Regional Directors will be located. To help in planning a location for the Prime contractor's senior executive within a 15 minute drive of the Regional Director's office, may we assume that the Regional Directors will be located at the following commands?
North - Walter Reed
South - Wilfred Hall
West - Naval Medical Center San Diego

RESPONSE: The technical evaluation will not evaluate this requirement. For the cost proposal, offerors should base their costs on the cost of leasing or buying a facility the identified cities.

681. These two answers in the latest question set seem to contradict each other. Can you please clarify?

30. RFP Section C-7.12. & C-&.15. pages 27 & 28, Will beneficiaries currently enrolled to a network PCM under the present contract be reuired to transfer enrollment to an MTF PCM if capacity exists at the start of the new contract or anytime during the term of the new contract? (Received 16 August 2002)
Response: If the MTF capacity allows additional enrollees to the MTF, current network enrollees may be provided the opportuntiy to enroll to the MTF. However, current network enrollees will not be forced to change their enrollments.

376. Section C-7.15 of the RFP requires the incoming contractor to enroll all Prime beneficiaries to their assigned PCM. If a beneficiary was enrolled to a civilian PCM with prior contractor, will they need an exception from the MTF Commander as described in section C-7.12?
Response: Yes

RESPONSE: ***revised 20 September 2002***

RESPONSE: In an upcoming amendment, Section C-7.15. will be changed to read, "If a beneficiary's civilian primary care manager remains in the TRICARE network, the beneficiary may retain their primary care manager. If the beneficiary must change primary care managers, all enrollments shall be to the MTF until MTF capacity, as determined by the MTF Commander, is reached."

682. Ref: Question 377 and response. How is the contractor going to know when a patient requests an appointment.

RESPONSE: The offeror should propose its best commercial practices on how it will to meet the access standards.

683. Your response to question 426 states that the current list of Health Benefits Advisors and Beneficiary Counseling and Assistance Coordinators is available on the TMA website. We have located the list of Beneficiary Counseling and Assistance Coordinators on the TMA web site but have not been able to find a listing of the Health Benefits Advisors. Could you please identify the specific location of the HBA listing on the TMA website.

RESPONSE: You are correct; there are no HBA listings on the web site. Since the BCAC function and the HBA function are usually co-located, assume for each BCAC there is also a HBA and plan accordingly.

684. The TRICARE Systems Manual 7950.1-M states the contractor shall install a prepayment eligibility verification system into its TRICARE operation that results in a query against DEERS for TRICARE claims and adjustments. After searching the RFP and supporting material, we have not been able to locate the specific file layouts required for the DEERS query and response transactions. Under the current MCS contracts, Chapter 9 of the ADP Manual has all the file layouts for the query and response records that need to be sent between DEERS and the MCSC/FI for an eligibility inquiry. Where can we find the file layouts that will be required under TNex?

RESPONSE: File layouts for DEERS transactions will be provided at the technical specifications meetings following contract award. The business rules in Chapter 3, Addendum D of the TRICARE Systems Manual provide the data elements for each

business event. Located on the DMDC website, <www.dmdc.osd.mil/deers> is the DEERS New Medical Data Dictionary, Version 1.1. The Data Dictionary provides the data element names, definitions, display lengths, and code values. The file layouts, that will be provided following contract award, will provide the order of the data elements within the transactions and the specific structure of the message.

685. During the annual renegotiation to set target healthcare costs, the contractor should take into account the number of beneficiaries, MTF workload, and other factors beyond its control.

a. What data (such as MTF workload, DEERS) will be supplied to contractors to assist them in making this determination?

RESPONSE: The Government will work with the contractor to develop the data elements required to achieve a successful negotiation. Please remember, however, that the contractor will possess all purchased care data, which represents the target health care costs. The contractor will also be provided with the DEERS STAT II reports on a regular basis to update the number of beneficiaries within the region.

b. Also, will recent data from prior to contract award be available to help negotiate the earlier OPs? (The negotiation for OP2 will start when little historic OP1 data is available.)

RESPONSE: The Government will provide that available data which is mutually agreed upon as necessary for successful negotiations.

686. Will change orders be issued and negotiated as far as health care costs for routine updates in CHAMPUS reimbursement levels?

RESPONSE: No. Please see the TOM, Chapter 1, Section 4 paragraph 2.4.; routine updates in reimbursement levels are to be included in the offeror's overall bid.

687. Data Tapes: We have been attempting to discern what the required Prime Service Areas are in the TNEX contract. The data package released with the RFP contains several zip code lists. These lists separately designate zip codes within each region as belonging to a catchment area, a BRAC area, a noncatchment prime (NCP) area, a TRICARE Prime Remote (TPR) area, or a noncatchment area. Many zip codes are contained in more than one of the above lists. The purpose of this question is to determine how the government treats the areas that are listed in more than one of the above categories. Please address the specific instances below.

a. If a zip code is in both catchment and another list, it appears that the zip code should be considered to be in a catchment area. Is this correct?

RESPONSE: If the zip code is in an MTF or BRAC catchment area, then it is to be considered a catchment area.

b. If a zip code is in both the BRAC and NCP lists, in what type of area does the government consider that zip code to be?

RESPONSE: For the current contracts, the contractor has promised and is required to offer both Prime and Extra in that zip code. If the offeror does not offeror non-catchment Prime in that zip code, the contractor, based on the BRAC designation, is

still required to develop and implement a network that provides both Prime and Extra.

c. If a zip code is in both the BRAC and TPR lists, in what type of area does the government consider that zip code to be?

RESPONSE: For this solicitation, the family members who meet the requirements of the TRICARE Prime Remote Program (TPR) will be enrolled in the TPR Program. Those individuals, including active duty family members, who would not meet the TPR requirements would be offered Prime enrollments to a network that meets all access standards which would be subject to the performance guarantees.

d. If a zip code is in the BRAC, NCP, and TPR lists, in what type of area does the government consider that zip code to be?

RESPONSE: For this solicitation, the family members who meet the requirements of the TRICARE Prime Remote Program (TPR) will be enrolled in the TPR Program. Those individuals, including active duty family members, who would not meet the TPR requirements would be offered Prime enrollments (due to the requirement for a network in BRACs) to a network that meets all access standards which would be subject to the performance guarantees

e. If a zip code is in both the NCP and TPR lists, in what type of area does the government consider that zip code to be? (Note: this is the case for most zips in Alaska, Hawaii, California, and Nevada, as well as many in Oregon and Colorado)

RESPONSE: For the current contracts, the contractor has promised and is required to offer both Prime and Extra in that zip code. If the offeror does not offeror non-catchment Prime in that zip code, the contractor, based on the TPR designation, is required to meet the network requirements of the TPR Program.

f. Zip code 67843 is not listed in any of the government files released with the RFP. How should the contractor classify this zip code?

RESPONSE: This would be a zip code that Prime is not either required by the Government or not being offered by an incumbent.

g. Around areas designated as catchment or BRAC, there is often a ring of a few zip codes designated only as noncatchment, which are in turn surrounded by other noncatchment zips which are designated as either NCP or TPR areas. For example, the zip codes immediately surrounding Colorado Springs, CO, are all designated as catchment zip codes. Bordering these zips are 11 zip codes designated as non-catchment zip codes. The zip codes further out from these non-catchment zip codes are nearly all TRICARE Prime Remote zip codes. Is this correct?

RESPONSE: Yes

h. In the following states, a previous catchment area is not listed in the catchment file. Should these areas, shown by the prior DMISID, be considered catchment areas? KS(058), UT(119), WA(128), ND(093,094), NM(083,084,085), MO(058,076), ID(053,128), AZ(008,010), WY(129), SD(106), CO(129), MT(077). If yes, please provide a complete list of zip codes. If no, should these zip codes be listed as TPR or NCP?

RESPONSE: With one exception, the catchment areas in question are no longer in the catchment file due to downsizing of inpatient facilities and should not be considered catchment areas. The following areas became non-catchment in the CAD as of the following CAD effective dates:

KS(058) downsized effective 1 Nov 97
UT(119) downsized effective 1 Jul 99
WA(128) downsized effective 1 Nov 98
ND(093,094) downsized effective 1 Jan 01 and 1 Oct 99, respectively
NM(083,084,085) downsized effective 1 Oct 99, 1 Jan 00, and 1 Apr 99, respectively
MO(058,076) Missouri has no DMIS ID 058 - that DMIS belongs to Kansas and represents Ft. Leavenworth (see KS above), 076 downsized effective 1 Nov 97
ID(053,128) DMIS 053 is still an inpatient facility (see last paragraph), DMIS 128 represents Fairchild AFB in Washington (not Idaho) and was downsized effective 1 Nov 98
AZ(008,010) downsized effective 1 Nov 97, and 1 Jan 00, respectively
WY(129) downsized effective 1 Oct 99
SD(106) downsized effective 1 Oct 99
CO(129) DMIS 129 belongs to Wyoming and represents F.E. Warren (see WY above)
MT(077) downsized effective 1 Oct 89.
ID(053) represents Mountain Home AFB in Idaho and is still an inpatient facility.

i. In several cases, a single zip code of a particular type will be surrounded completely by dissimilar zip codes. It appears unusual to have these isolated zip codes. In the cases below, a zip code designated one type by the government would seem to make more sense as another type. Please verify in each specific case which type the zip code should be designated.

Zip CODE	of TYPE	in STATE	is surrounded by zip codes of TYPE
85742	BRAC	AZ	NC
85215	BRAC	AZ	Catch
85240	BRAC	AZ	NC
80429	NCP	CO	TPR
80475	BRAC	CO	TPR
82824	NC	ID	TPR
83301	NCP	ID	TPR
83713	TPR	ID	NCP
59319	NC	MT	TPR
59484	NCP	MT	TPR
63646	NC	MO	TPR
65054	NC	MO	TPR
65064	NC	MO	TPR
64478	NC	MO	TPR
64015	NCP	MO	NC
64012	NCP	MO	NC
64083	NCP	MO	NC
64078	NCP	MO	NC
64063	NCP	MO	NC
64086	NCP	MO	NC
67442	NC	KS	TPR
66855	NC	KS	TPR
67103	NC	KS	NCP

67135	NC	KS	NCP
67021	NCP	KS	TPR
67028	NCP	KS	TPR
67029	NCP	KS	TPR
67111	NCP	KS	NC
99327	NC	WA	TPR
99147	NC	WA	TPR
98647	NCP	WA	TPR
98244	TPR	WA	NCP
82713	NC	WY	TPR
82070	NCP	WY	
NC/TPR			

Additionally, the following group of only 3 NCP zip codes in Nevada is surrounded by TPR zip codes: 89406, 89408, 89427.

If the Government would prefer not to research and answer the above questions, we request that the Government send one tape or electronic file to those who requested the data tapes with the required Prime service area ZIP codes. This should include the 40-mile radius around an MTF and also other required Prime areas such as BRAC sites and expanded Prime areas.

RESPONSE: The Government will be providing a new data set of the non-catchment area zip codes that were either mandated by the Government or offered by the contractor. This tape will include those non catchment area zip codes that are also TPR zip codes. With this new data, and the prior BRAC, catchment area, and TPR zip codes offerors will have the required data to determine where they are required to establish Prime or TPR as required to meet the requirements of the TPR Program. . The non-catchment area zip codes contain zip codes that a TRICARE civilian network is currently provided by a MCS contractor but the government has not mandated for this contract that a network be established.

688. Question 80 on the TNEX Website requested the last three-year enrollment revenue by Region and the Government's response was this was proprietary and not releasable. We would like an explanation as to how this is considered proprietary considering the Government sets the fees and this information is reported to the Government as part of the Bid Price Adjustment. We believe that not receiving this information would cause competitive disadvantage concerns. We request that the Government readdress this.

RESPONSE: The Government researched its response to question 80 (now numbered 82) regarding enrollment revenue and reconsidered. The response to question 82 has been revised to provide the requested data.

689. This is in response to the Government's response to questions #67 concerning C-17.21.18. The Government's response appears to say that health care costs for Prime enrollees paid to non-network provides that did not accept assignment and were paid at 115% are to be borne by the contractor, if the contractor referred the beneficiary. At the TRICARE T-NEX Bidders Conference on August 28th, the government stressed that "Large size [provider networks are] not necessarily positive," in its presentation to prospective bidders; Chapter 11, Section 1.2 of the August 1st, 2002 T-NEX TRICARE Policy Manual allows non-participating TRICARE providers to charge the Balance Billing Limit, which is defined as 115% of CMAC;

Chapter 17, Section 6 paragraph 4.0 of the August 1st, 2002 T-NEX TRICARE Operations Manual states that "the TPRADFM program has no additional network development requirements, except where contractually required or economically feasible;" Chapter 17, Section 6 paragraph 14.5 of the August 1st, 2002 T-NEX TRICARE Operations Manual allows MCSCs to pay non-participating TRICARE providers up to 115% of CMAC for TPRADFM enrollees; Chapter 19, Section 3 paragraph 8.2 of the August 1st, 2002 T-NEX TRICARE Operations Manual defines MCSCs responsibilities to provide care to SHCP beneficiaries by paying up to 115% of CMAC, and even requesting special waivers of CMAC limitations; Section C-2.1 of the T-NEX Solicitation gives priority to beneficiary health and customer satisfaction in Objective 2 of the MHS stating, "Beneficiary satisfaction at the highest level possible throughout the period of performance, through the delivery of world-class health care as well as customer friendly program services. Beneficiary must be highly satisfied with each and every service provided by the contractor during each and every contact." The government has repeatedly stated MCSCs rights and responsibilities to make alternative contractual arrangements with non-participating providers and has stressed its priority to assure "world-class health care" and "highly satisfied" beneficiaries in its official manuals which define the MCSC contracts.

We believe it is legally inconsistent to allow, and even contractually require, MCSCs to pay providers in excess of CMAC, yet to not include these excess payments as underwritten health care costs, as we believe the government has stated in their response to Question #67. To clarify:

a. Is it the Government's intent that the claims costs between 100%-115% referred by the contractor for a Prime beneficiary be paid solely by the contractor? If so, (a) please outline what the process TMA will be using to separate these amounts in the claims data and how it will be paid as TEDs clear. Then (b) indicate how this will be shown to the MTFs for the revised refinancing portion of the claims.

RESPONSE: Yes, you have correctly interpreted the Government's requirement. The process is that the contractor will only report an allowed amount of 100% of CMAC and paid amounts that correctly represent what the Government would have paid based off this allowed amount.

b. We assume that for the purposes of C-7.21.18. the TPRFM program is excluded as there is no network building requirement. Please confirm.

RESPONSE: Confirmed, if the beneficiary is outside of a TRICARE Prime service area.

c. We also believe that the SHCP program should be excluded. Please address.

RESPONSE: Confirmed, if the beneficiary is outside of a TRICARE Prime service area.

d. We believe that the government should consider amending its response to this question and to consider these as underwritten health care costs as defined in Section H-1(b)6(a). Please address.

RESPONSE: Thank you for your comment.

690. It would be very helpful just to get the new responses and responses that have changed, RATHER than having to download a 679 question document, print the whole thing, and try to figure out yourself what has (or has not) changed.

RESPONSE: We have considered your request and are now providing the information requested via email to those interested parties registered on the TRICARE solicitation website for the Managed Care Support solicitation.

691. Although I downloaded and incorporated the pages of the mod when they were issued, upon a more careful review I see the pages that have changes are not identified as being Amendment 1. Also the Solicitation Changes pages incorrectly lists changes applicable to section L-13 as being in L-12. I assume others may have found and raised these as issues. If so please disregard this message since I assume that these corrections will appear in the next amendment. If not when will they be corrected?

RESPONSE: You are correct; the changed pages of the various sections of the solicitation are not identified as Amendment 0001. They are not identified as such because the automated system used by the TRICARE Management Activity does not perform that function.

Regarding solicitation changes incorrectly listing changes applicable to L-13 as being in L-12: Amendment 0001 changed paragraph L-12 to L-13.

692. I set up a matrix to track answers and revisions to questions. When matching my matrix against the new responses today I noticed a problem that has developed in the numbering system. At first I thought there had been two new questions inserted between no. 1 and no. 76. What has happened is that Q 64 is missing, although the response is there. Q69 used to be 68(a) and 78 was 76(b). From that point all the numbering is off by two. At that point I stopped checking. I don't know how many other mistaken changes have occured, but given the volume of Q&As it's essential that numbering remain consistent. Please restored the numbering to its original sequence.

RESPONSE: The numbering scheme was revised in the questions and answers set in hopes of dispensing with the confusion created by the error. Some interested parties were of the belief questions and answers were missing. The Government reviewed all questions submitted and verified it was an error in the numbering scheme only; no questions were omitted from the questions and answers document. In an effort to alleviate potential confusion, a notification email was sent to those parties registered for the Managed Care Support solicitation stating the numbering scheme was revised and follow-on notification emails have provided the revised number along with the previous number of the question.

The numbering scheme to the questions and answer document will not be changed.

693. Thank you for restoring questions missing from the 9/9/02 issue, but in today's set all the questions that were added on 9/9, from Q680 through Q706 are now missing, while three new ones have been added as Q679, Q680, and Q681. Will the original numbering be restored?

RESPONSE: There have been some information technology problems in the conversion of the questions and answers Word document into an Adobe Acrobat pdf

file. The Government reviewed the questions and answers document and found all questions submitted were accounted for. Please refer to the response to question 692.

694. I'm not sure how practical this request is but would it be possible to post the question numbers of the "New Answers" that are posted on the webpage?

RESPONSE: The Government has considered your request and is now providing the information requested via notification email to those interested parties registered on the web for the Managed Care Support solicitation.

695. Section L.13.f.(2)(d) requires first-tier subcontractors to submit a past performance report for each of their current top five overall accounts based on gross revenues. Section L.13.f.(2)(g) requires first-tier subcontractors to provide certain information concerning for their top three accounts terminated or not renewed within the 36 months prior to submission of the proposal. In certain cases, one of the top five overall accounts or one of the top three terminated accounts may be a firm that is competing for a prime contract or major subcontract in response to this RFP. In that circumstance, the entity providing past performance information has a clear conflict of interest. It would be in the competitive interest of the entity providing past performance information to provide a negative evaluation of the work performed. In this circumstance, it would appear that TMA has two options: amend the RFP or ignore adverse past performance information received from a firm competing for a prime contract or major subcontract in response to this RFP.

a. Will TMA amend the RFP to solve this problem? (For example, it could state that no firm that is competing for a prime or subcontract in response to this RFP should provide past performance information on another entity seeking a prime or first-tier subcontract. Alternatively it could instruct offerors and their first-tier subcontractors not to request information from any firm it believes is competing for a prime contract or subcontract in response to this RFP and instead to request information from the next largest account.)

RESPONSE: No, the Government will exercise its judgement in evaluating all past performance information.

b. If TMA does not amend the RFP, will TMA agree that it will not consider any adverse past performance information received from a firm competing for a prime contract or a subcontract in response to this RFP? (See International Consultants, Inc., B-278165, Jan. 5, 1998, 98-1 CPD para 7, n. 3.)

RESPONSE: No. Offeror’s have the opportunity to address information submitted by their clients in their proposal. The Government will then use its judgement in evaluating the information.

696. Your response to question # 30 indicates that enrollees with civilian PCMs will not be forced to change to an MTF PCM even if capacity exists at the MTF; however, your answer to question # 378 indicates that the beneficiary would be required to ask the MTF Commander for an exception in order to continue with the civilian PCM. Will beneficiaries in this situation be required to ask the MTF Commander for an exception but not be required to change PCMs if the Commander denies the request?

RESPONSE: In an upcoming amendment, Section C-7.15. will be changed to read, "If a beneficiary's civilian primary care manager remains in the TRICARE network, the beneficiary may retain their primary care manager. If the beneficiary must change primary care managers, all enrollments shall be to the MTF until MTF capacity, as determined by the MTF Commander, is reached."

697. RFP Section J, Attachment 8, states that Prime non-catchment area zip codes are contained in the T-NEX Reference Files. We believe the data for the Prime non-catchment file was constructed based on a TMA letter dated June 14, 2002, which requested that contractors provide their "current zip code file for non-catchment Prime areas, excluding those zip codes in TRICARE Prime Remote (TPR) areas." TPR areas are extensive across the United States. When the zip codes for TPR areas are excluded from Prime non-catchment areas, the remaining zip codes significantly understate the size and location of existing Prime non-catchment areas. Offerors who base their proposals for offering TRICARE Prime in non-catchment areas on data which has been provided by the Government will exclude many beneficiaries who are currently enrolled in the Prime program. A contract awarded based on a response to these data will result in extreme beneficiary dissatisfaction for those who loose their Prime benefits. Will the Government provide corrected Prime non-catchment area zip code data in time for submission of proposals?

RESPONSE: The Government has requested the incumbent contractors to review the data provided to the Government, and if warranted, provide us with an update which we will immediately issue to those offerors who requested the data package. Where a zip code is considered both a TRP and a Prime non-catchment area zip code, it will be included.

698. C2.1. Objective 4. The Government has placed a high premium on minimum disruption during the transition periods. The Government's refusal to allow offerors to conduct MTF site visits to learn about each MTF's needs and wants therefore is puzzling. Without site visits, offerors will find it difficult to propose programs and processes that meet the needs of individual MTFs, thus making a smooth transition harder to achieve.

RESPONSE: Please see our response to question 585.

699. C7.1.12. If the contractor has medical management procedures that work differently from another contractor's, how will the contractor be able to convey that information in the absence of regionally specific marketing materials?

RESPONSE: The contractor will provide the Marketing and Education contractor with their information pursuant to the provisions of Section C-7.9

a. Will the Marketing and Education contractor develop marketing materials to allow for regional variation in the content of the procedures that providers and beneficiaries must follow?

RESPONSE: Yes.

700. C7.1.3. In its response to Question 143, the Government stated that "very little" interaction was required between the Managed Care Support contractor and the TRICARE Dual Eligible Fiscal Intermediary contractor, specifically stating that the TDEFIC would adjudicate claims through its own authorization activity. The TDEFIC

RFP states that the TDEFIC must receive authorizations from the Managed Care Support contractor. Please clarify.

RESPONSE: The TDEFIC solicitation has been changed. The is no requirement for the MCSC to provide authorizations to the TDEFIC contractor, except as a beneficiary assistance activity.